No Health without Mental Health
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March 24, 2022

EXECUTIVE SUMMARY - NHMH POSITION ON HOUSE BILL HR 5218 -

Training Program for Primary Care Practices to Integrate Behavioral Health Services

1) NHMH is pleased to see HR 5218 as the first behavioral integration bill in Congress. Beginning in 2007, we have advocated for medical setting practitioners to receive supports and incentives necessary to allow them to incorporate behavioral health services into their practices.
2) That said, NHMH and the undersigned organizations believe the scope of the bill should be expanded to include the evidence-based Primary Care Behavioral Health (PCBH) model, also known as the Behavioral Health Consultant (BHC) model, as a standalone integration services model,
3) The PCBH and collaborative care (CC) models of integration are *both* evidence-based and are *also* highly complementary in their goals and practices. Experts have suggested they would fit nicely in a stepped sequence. (Reiter et al, 2018, *Jnl of Clin Psych in Med Set*; Unutzer, 2016, *Psych News*).
4) Currently, primary care providers (PCP) have 4 options to choose from, alone or in combination, to integrate BH services into their clinics: (1) Usual care – PCP only treatment of BH conditions; (2) SBIRT intervention for alcohol misuse conditions; (3) PCBH model services consultant approach for BH problems and biopsychsocially (BPS)- influenced health conditions, and (4) CC model services primarily for highly prevalent mood disorders (depression, anxiety).
5) The PCBH model has a solid evidence base and is distinctive in its high level of patient-centeredness:
    - Designed specifically for primary care (PC): PCBH organically grew out of, the PC clinical environment; it was built specifically to align with primary care
    - Aligned with the PCMH innovation: PCBH meant to fill a gap in PCMH, i.e. lack of strategy for helping with the large numbers of BPS-influenced health conditions in primary care
    - Team-based: BHC is an embedded member of the PC team
    - Population based: BHC available to assist with treating the entire clinic patient population regardless of age, ethnicity and/or condition
    - Highly accessible: offering usually same-day services and follow-up appts
    - Tested: PCBH model has been successfully implemented in a wide variety of real-world clinical care environments with a diverse group of patients of varied ages, ethnicities and diagnoses.
    - Face2Face Interaction: between patient and BHC
    - High Level of Care Coordination: Patients are followed by both the BHC and PCP until symptoms and/or functioning improve, and can re-engage at any time.

NHMH – No Health without Mental Health
American Association on Health & Disability
Association of Medicine & Psychiatry
Clinical Social Workers Association
Lakeshore Foundation
Maternal Mental Health Leadership Alliance

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FURTHER BACKGROUND re

NHMH POSITION ON HOUSE BILL HR 5218 -

TRAINING PROGRAM FOR PRIMARY CARE PRACTICES TO INTEGRATE BEHAVIORAL HEALTH SERVICES

NHMH and the undersigned organizations believe the scope of HR 5218 should be expanded to include the Primary Care Behavioral Health (PCBH) model because:

#1: PCBH is a proven, evidence-based integrated care delivery model with unique population reach

#2: PCBH model services are uniquely patient-centric

#3: The U.S. is in the midst of a massive mental health – addiction care delivery crisis

PART ONE: PCBH Has a Solid Evidence Base As An Integrated Services Model

Overview of Proven Approaches: When considering approaches to integrating BH services primary care (PC) practices/systems now have 4 choices, to deploy alone or in combination:

1. Usual care -- primary care provider (PCP)-only treatment of BH conditions
2. SBIRT (Screening, Brief Interventions, Referral to Treatment) intervention for alcohol misuse
3. PCBH model services
4. CC (collaborative care) model services

There are currently 3 evidence-based approaches to integration of behavioral health (BH) services in medical settings, all proven effective: SBIRT; PCBH and CC. These 3 approaches are complementary with respect to their goals and practices (Reiter et al, *Jnl Clinic Psych in Med Set*, 2018, 25:109-126; Unutzer, 2016, Psych News). Some well-resourced practices deploy all 3. The brief SBIRT interventions can be provided by a behavioral health consultant (BHC) using the PCBH model. Both the SBIRT and CC population approaches to integration focus on specific health conditions (SBIRT on substance misuse, CC on mood disorders) while the PCBH model focuses on the entire clinic population. Ultimately, which integration approaches are adopted by primary care practices and systems will depend on their own goals, resources and patient needs. But a consensus exists in the field that all have a solid evidence base, are proven effective and, we believe, should be supported by federally funded training programs.

PCBH Defined: The PCBH model is a team-based approach to **managing BH problems and bio-psycho-socially (BPS) influenced health conditions** *in primary care*. PCBH was developed for, and organically grew out of, the primary care clinic environment. Its goal is to enhance the primary care (PC) **team's** ability to manage and treat such problems/conditions **with** resulting improvements in PC services for the

entire clinic population. (Reiter, 2018). PCBH does not involve the use of new BH interventions, rather it is a new delivery platform for delivering interventions, and components thereof, already found effective in other PC settings, e.g. CBT, MI, BA etc.

PCBH works by incorporating a BH consultant (BHC) into the primary care team to extend and support the primary care provider (PCP) and team. The BHC -- usually a clinical psychologist, licensed clinical social worker, or psychiatric provider -- works as a generalist and an educator, who sees patients of all ages and conditions, and by their work aims to improve the PCP and the team's BPS management of health conditions in general. The BHC provides high-volume services that are accessible, team-based and constitute a routine part of primary care.

The BHC assists in the care of patients of any age and with any health condition. (Studies found the PCBH model resulted in significant improvements in conditions involving anxiety, depression, PTSD, tobacco use, and weight change. Hunter, Funderburk et al, 2017).

The BHC aims to intervene with all patients on the day they are referred, hence highly accessible; shares same clinic space and resources of PC team and assists team in variety of tasks, hence team-based; engages with a large percentage of clinic population, hence high-reach; helps improve the PC team's BPS assessment and intervention skills and processes, hence educative; and is a routine part of BPS care.

The BHC uses focused 15-30 minute visits to assist with specific symptoms or functional improvement. Follow-up is based in a consultant approach in which patients are followed by the PCP and BHC until functioning or symptoms begin improving, at which point the PCP resumes sole oversight of care but can re-engage the BHC at any time as needed. Patients not improving are referred to higher intensity care and/or specialty mental health setting.

PCBH and CC Compatibility: PCBH and CC can fit nicely together both in theory and in practice. The CC goal is to improve treatment response for certain select conditions (depression, anxiety) while goal of PCBH model services is more broadly focused on improving care for the whole clinic population.

The CC approach focuses on treating depression and anxiety. It adds an enhanced focus on medication treatment, psychiatry involvement, and longer-term, registry-driven follow-up. The CC model can be an excellent complement to the PCBH model services (Unutzer; Reiter). Many patients with BPS conditions or BH problems in primary care will improve after seeing a PCP alone or with a BHC, i.e. without CC. Those not improving may benefit from enrollment in CC services.

PART TWO: PCBH Model Is Distinctively Patient-Centric

First, the PCBH model **is highly aligned with the Patient Centered Medical Home (PCMH**), whose Joint Principles were published and endorsed by 4 primary care professional societies in 2007, the American Academy of Family Medicine (AAFP), the American Academy of Pediatrics (AAP), the American College of Physicians (ACP), and the American Osteopathic Association (AOA). The PCMH is meant to shift primary care from a physician-centric approach to a team-based approach, with new PC team members extending the reach and impact of care as compared to traditional PC services. The PCBH is intended to

fill a gap in the PCMH innovation: a lack of a strategy for helping with the vast number of BPS influenced health conditions present in primary care.

Second, the PCBH model's components and strategies were **built specifically to align with primary care**: a convenient and familiar location of care; easy access, usually same day; team-based treatment plan; a focus on whole person care.

Third, **data** supporting the PCBH evidence base has been **collected in real-world clinical care environments with a diverse group of patients of varied ages, ethnicities, and diagnoses.** This broad range of patients and clinical sites increases the validity of the data supporting the PBH model (Reiter, p. 121). Data on PCBH implementation and outcomes has been collected in a wide variety of clinical settings: in internal medicine and family medicine clinics, pediatrics services, military sites, VA facilities, community health facilities, and university health centers.

Fourth, PCBH model services are based on direct, **face2face interactions with the BH provider** (BHC) and the patient, not just indirect contact from offsite behavioral health professionals.

Fifth, patients appreciate the **closely coordinated care services** they receive in the PCBH model. National surveys show that 90% of Americans want both their medical and behavioral issues addressed together in a coordinated way. With the PCBH approach, the PCP brings in the BHC sometimes directly into the exam room during a clinic visit, both the PCP and BHC oversee integrated care, and the BHC consultant is always available to re-engage with the PCP should patient relapse. Both the PCP and BHC chart into the same EMR and share in carrying out a common treatment plan.

Sixth, the PCBH model **builds on and strengthens the PCP-patient relationship**, the foundation of all healthcare delivery. Patients can see that this integration model was designed for, and fits easily into, the PC setting, and is meant to address PC patients needs as well as clinical care and operational needs.

PART THREE: U.S. in Midst of an Extraordinary Crisis of Untreated Behavioral Health Conditions

The U.S. is in the midst of a mental health and addiction services delivery crisis of unprecedented proportions. Approximately 75% of all patients with behavioral health conditions go only to primary care. Thus, *all evidence-based* models of behavioral integration in primary care should be supported where/whenever possible to meet the MH needs of Americans in this crisis environment.

Two respected mental health advocacy organizations, the Well Being Trust (2021) and National Alliance on Mental Illness (2020) report that:

- Prior to COVID, 1 in 5 U.S. adults experience mental illness each year, and 1 in 20 experience serious mental illness each year
- 1 in 6 U.S. youth aged 6-17 experience a mental health disorder each year
- Suicide is the 2nd leading cause of death among people aged 10-34
- Suicide is the leading cause of death for women in the first year following pregnancy
- 33% of BH patients wait more than a week to access a BH clinician
- One-third of hospital stays are now related to mental health diagnoses

- Annually only 10% of people with SUDs receive any treatment
- On average 130 Americans die every day from an opioid overdose
- $500+ billion is the annual opioid overdose cost in the U.S.
- In 2021 overdose deaths reached 100,000, 5x higher than in 1999 (Source: CDC)

Sources:

(https://wellbeingtrust.org/wp-content/uploads/2021/08/WBT_Peoples-Guide-to-Healing-the-Nation-2021-FINAL.pdf).

https://www.nami.org/mhstats

Respectfully submitted,

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American Association on Health & Disability
Association of Medicine & Psychiatry
Clinical Social Workers Association
Lakeshore Foundation
Maternal Mental Health Leadership Alliance